Preparing Claims

Claims Submission

All claims, whether electronic or paper, are subject to the same Wisconsin Medicaid processing and legal requirements.

Electronic Claims Submission

Providers are encouraged to submit claims electronically. Electronic claims submission:

- Reduces processing time.
- Eliminates manual handling of claims.
- Reduces both billing and processing errors.

Wisconsin Medicaid provides software for submitting claims electronically. For more information on electronic claims submission:

- Refer to the Claims Submission section of the All-Provider Handbook.
- Contact the Electronic Media Claims (EMC) Department at (608) 221-4746. Ask to speak with an EMC coordinator.

If you are currently using the software and have technical questions, please contact Wisconsin Medicaid's customer service at (800) 822-8050.

Paper Claims Submission

Providers submitting paper claims must use the HCFA 1500 claim form (dated 12/90). Refer to Appendices 6 and 7 of this handbook for HCFA 1500 claim form completion instructions and a completed sample.

Wisconsin Medicaid denies claims for services submitted on any paper claim form other than the HCFA 1500 claim form.

Wisconsin Medicaid does not provide the HCFA 1500 claim form. Providers may obtain the form from any vendor that sells federal forms.

Where to Send Your Claims

Mail completed HCFA 1500 claim forms for reimbursement to the following address:

Wisconsin Medicaid
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Claims Submission Deadline

Wisconsin Medicaid must receive properly completed claims within 365 days of the date the service was provided. This policy applies to all initial claims submissions, resubmissions, and adjustment requests.

Exceptions to the 365-day claims submission deadline, requirements for submission to Late Billing Appeals, and adjustment information can be found in the Claims Submission section of the All-Provider Handbook. Providers may access the handbook online at *www.dhfs.state.wi.us/medicaid/*.

Claim Components

Diagnosis Codes

Independent laboratories may use the general diagnosis code V72.6 for laboratory exams or the appropriate diagnosis code from the most current *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) for each symptom or condition related to the services provided. Code V72.6 may apply to most independent laboratory procedures, with the exception of services provided to presumptively eligible pregnant women. These claims must include a pregnancy-related diagnosis code.

Wisconsin Medicaid denies claims received without the appropriate ICD-9-CM diagnosis code or without the general diagnosis code V72.6 for laboratory exams.

Independent laboratories may use the general diagnosis code V72.6 for laboratory exams or the appropriate diagnosis code from the most current *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) for each symptom or condition related to the services provided.

Procedure Codes

Wisconsin Medicaid requires that all HCFA 1500 claim forms have either a HCFA Common Procedure Coding System (HCPCS) code, a current *Current Procedural Terminology* (CPT) code, or a local Medicaid code that best describes the procedure performed. Wisconsin Medicaid denies claims or adjustments without the appropriate code.

Wisconsin Medicaid does not allow reimbursement for all CPT codes (e.g., fertility-related services are not covered). In addition, the procedure code billed must be appropriate for the Clinical Laboratory Improvement Amendment (CLIA) certification type indicated in the billing provider's Medicaid file.

Refer to Appendix 4 of this handbook for allowable procedures and Appendix 5 of this handbook for type of service (TOS) and place of service codes for independent laboratory services.

Complete Procedure vs. Professional and Technical Components

Most laboratory services are performed and reimbursed as a complete procedure (TOS "5").

A relatively small number of laboratory procedure codes have technical (TOS "U") and professional (TOS "X") components. Nevertheless, these procedures are billed as a complete procedure (TOS "5") when both the technical and professional components are billed by a single laboratory. A *written report* must be produced and maintained in the recipient's medical record when one of these procedure codes (having technical and professional components) is billed with either a TOS "X" or "5."

At times the technical component is performed by a physician clinic but the professional component is performed by an independent laboratory. In this situation, each provider bills and is reimbursed only for the service performed, as follows:

- The provider performing the technical component bills only the technical component (TOS "U").
- The independent laboratory performing the professional component bills only the professional component (TOS "X"). Remember that the professional component must result in a written report that is kept in the recipient's medical record.

The complete procedure (TOS "5") is not reimbursable to either provider in this situation.

The attending physician's clinical interpretation of laboratory results is not separately reimbursed because it is included in Wisconsin Medicaid's reimbursement for the physician-patient encounter (i.e., the evaluation and management service).

Unlisted Procedures

Claims submitted for an unlisted (nonspecific) procedure code (e.g., procedure code 81099) require documentation describing the procedure performed. The documentation must be sufficient to allow the Divison of Health Care Financing chief medical officer to determine the nature and scope of the procedure and whether the procedure was medically necessary as defined in HFS 101.03(96m), Wis. Admin. Code.

If the procedure can be described and its medical necessity explained in a few words, providers may use Element 19 ("Reserved for Local Use") of the HCFA 1500 claim form. If there is insufficient space, write "see attached" in Element 19 and attach additional documentation to the claim.

New laboratory tests that have not received a CPT or HCPCS procedure code number should be billed as an unlisted procedure. Wisconsin Medicaid reimburses only tests that are approved by the federal Food and Drug Administration.

A *written report* must be produced and maintained in the recipient's medical record when one of these procedure codes (having technical and professional components) is billed with either a TOS "X" or "5."

Providers are required to bill their usual and customary charge for the service performed.

Modifiers

Wisconsin Medicaid accepts only the "QW" modifier for CLIA-waived procedures. Providers should use TOS "X" or "U" rather than modifier "26" or "TC" for professional or technical components. Refer to Appendix 1 of this handbook for a complete list of CLIA-waiver certificate procedure codes.

Billed Amounts

Providers are required to bill their usual and customary charge for the service performed. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Wisconsin Medicaid benefits. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

Providers may not discriminate against Wisconsin Medicaid recipients by charging Wisconsin Medicaid a higher fee for the same service than that charged to a private pay patient. For providers that have not established usual and customary charges, the charge should be reasonably related to the provider's cost to provide the service.

Reimbursement

Providers are reimbursed at the lesser of their usual and customary charge and the maximum allowable fee established by the Department of Health and Family Services.

The maximum allowable fee is the maximum amount that Wisconsin Medicaid will pay a provider for an allowable procedure code.

To obtain a maximum allowable fee schedule for independent laboratory services, providers may:

- Download an electronic version from Wisconsin Medicaid's Web site using directions located in the Claims Submission section of the All-Provider Handbook.

  Wisconsin Medicaid's Web site is located at *www.dhfs.state.wi.us/medicaid/*.

- Purchase a paper schedule by using the order form located in the Claims Submission section of the All-Provider Handbook or by writing to:

  Wisconsin Medicaid
  Provider Maintenance
  6406 Bridge Rd
  Madison WI 53784-0006

McKesson ClaimCheck®

Wisconsin Medicaid monitors claims for compliance with Medicaid reimbursement policy using an automated procedure coding review software known as McKesson ClaimCheck®. This software reviews claims submitted to Wisconsin Medicaid for billing inconsistencies and errors with respect to CPT codes.

ClaimCheck review may affect claims in one of the following ways:

1. The claim is unchanged by the review.
2. The procedure codes are rebundled into one or more appropriate codes.
3. One or more of the codes is denied as incidental/integral or mutually exclusive.

ClaimCheck monitors the following Medicaid policy areas:

1. *Unbundling* (code splitting).

   Unbundling occurs when two or more CPT codes are used to describe a procedure that may be better described by a single, more comprehensive code. ClaimCheck considers the single, most appropriate code for reimbursement when unbundling is detected.

   For example, if a provider submits separate claims for certain laboratory tests performed on the same recipient on the same date of service, ClaimCheck rebundles them into the single, most

appropriate panel (e.g., 80055 — obstetric panel, or 80076 — hepatic function panel).

ClaimCheck totals billed amounts for individual procedures. For example, if you bill three procedures at $20, $30, and $25, ClaimCheck rebundles them into a single procedure code, adds the three amounts, and calculates the billed amount for that rebundled code at $75. However, Wisconsin Medicaid reimburses the provider either the lesser of the billed amount or the maximum allowable fee for that procedure code.

2. *Incidental/integral procedures*.

   Incidental/integral procedures are those procedures performed as part of or at the same time as a more complex primary procedure. They require few additional physician resources and are generally not considered necessary to the performance of the primary procedure.

   When a procedure is either incidental or integral to a major procedure, ClaimCheck considers only the *primary* procedure for reimbursement.

3. *Mutually exclusive procedures*.

   Mutually exclusive procedures are procedures that would not be performed on a single recipient during the same operative session or that use different codes to describe the same type of procedure.

   When two or more procedures are mutually exclusive, Wisconsin Medicaid reimburses the procedure code with the highest provider-billed amount.

Claims Denied by ClaimCheck

Follow these procedures if you are uncertain about why particular services on a claim were denied:

1. Review the Explanation of Benefits denial code included on the Remittance and Status (R/S) Report for the specific reason for the denial.
2. Review the claim submitted to ensure all information is accurate and complete.
3. Consult current CPT publications to make sure proper coding instructions were followed.
4. Consult this handbook and other Wisconsin Medicaid publications to make sure current policy and claims submission instructions were followed.
5. Contact Wisconsin Medicaid's Provider Services at (608) 221-4746 for further information or explanation.
6. If circumstances warrant an exception, submit an Adjustment Request Form with supporting documentation and the words "medical consultant review requested" written on the form.

Follow-Up to Claims Submission

Providers are responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid. Processed claims appear on the R/S Report either as paid, pending, or denied. Wisconsin Medicaid will take no further action on a denied claim until the provider corrects the information and resubmits the claim, so that Wisconsin Medicaid receives the claim for processing within 365 days of the date of the original service.

If a claim was paid incorrectly, the provider is responsible for submitting an Adjustment Request Form to Wisconsin Medicaid. Refer to the Claims Submission section of the All-Provider Handbook for detailed information about the following:

- Adjustments to paid claims.
- Denied claims.
- Duplicate payments.
- Return of overpayments.
- The R/S Report.

Wisconsin Medicaid will take no further action on a denied claim until the provider corrects the information and resubmits the claim, so that Wisconsin Medicaid receives the claim for processing within 365 days of the date of the original service.